PELVIC FRACTURE CARE

Original Release/Approval		18 Dec 2004	Note: This CPG requires an annual review.	
Reviewed:	Nov 2008	Approved:	12 Nov 2008	
Supersedes:	JTTS Clinical Practice Guidelines for Pelvic Fracture Care, updated Apr 2008			

1. Goal. To provide a brief review for the stabilization and treatment of pelvic fractures sustained in combat casualties.

2. Background.

a. Injuries to the pelvis are relatively uncommon in the combat environment. Blunt trauma may be associated with major hemorrhage and early mortality, while penetrating trauma to the skeletal pelvis often results in injuries to abdominopelvic organs and almost uniformly requires exploratory laparaotomy.

b. Blunt trauma is typically associated with mechanisms as seen in the civilian population and can result in massive hemorrhage. Over 70% of the hemorrhage associated with blunt pelvic trauma is venous in nature and can be controlled with maneuvers that reduce the pelvic volume and stabilize the pelvis. The other 30% is associated with an arterial source and often requires operative intervention for retroperitoneal packing and damage control surgery.

c. A thorough examination of the pelvis and perineum are required to rule out associated injuries to the rectum and GU/GYN systems.

d. For all pelvic fractures, stabilization with whatever means are available (sheet, bean or sand bags, or pelvic external fixation, should be promptly implemented.

3. Evaluation and Treatment. See Appendix A

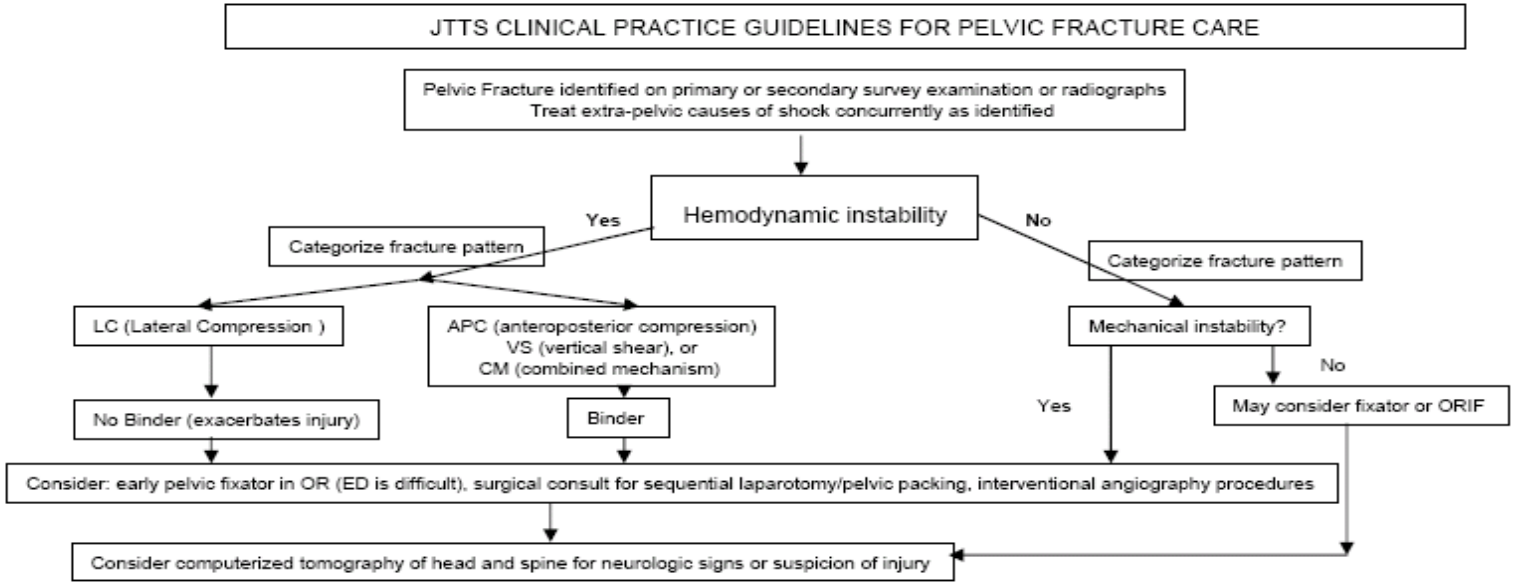
4. Responsibilities. It is the responsibility of the trauma team leader to ensure compliance with this CPG.

5. References:

[1] *Emergency War Surgery Handbook*

Approved by CENTCOM JTTS Director, JTS Director and Deputy Director and CENTCOM SG

APPENDIX A



Name	Abbreviation	Mechanically Stable	Mechanically Unstable	Associated injury Risk
Anteroposterior Compression	APC	APC1	APC2, APC3	Bleeding
Lateral Compression	LC	LC1	LC2, LC3	Head
Vertical Shear	VS	No VS is stable	All VS are unstable	Bleeding and Head
Combined Mechanism	CM	Only APC1, LC1	Includes APC2-3, LC2-3, or VS	Bleeding and Head